Leave of Absence Certification Form for Full-time Students Over the Dependent Age Limit

Subscriber Name: ______________________________

ID No.: ______________________________ **Group No.:** ______________

Dependent Name: ______________________________

Dependent Date of Birth: ______________________________

For purposes of establishing continued eligibility for dependent health care benefits, the undersigned certifies as follows:

I hereby certify that the dependent named above has been diagnosed and is currently being treated for the health condition noted below. Due to the serious nature of this condition, he/she is unable to attend school as a full-time student. As a result, I have recommended a medically necessary leave of absence beginning

______________________________.
Date

Diagnosis: ______________________________

Date of Onset: ______________________________

______________________________ ______________
Signature of Physician **Date**

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Name of Physician *(Please Print)*

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Address

____
City **State** **ZIP Code**